Cervical Cancer Screening Uptake and Associated Barriers: A Cross-Sectional Survey at Chawama Level One Hospital, Lusaka, Zambia

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ABSTRACT

Background: Cervical Cancer is globally ranked fourth cancer in women with the highest incidence and mortality in Africa. Screening for cervical cancer has proven to be effective in reducing the burden of the disease in developed countries. In Zambia, cervical cancer screening uptake has been repeatedly reported to be low. The objective of this study was to determine cancer screening uptake and associated barriers.

Methods: A cross-sectional design involving 384 antenatal and postnatal mothers at Chawama Level I Hospital in Lusaka was used. Questionnaires and Focus Group Discussions were used to collect data from mothers. Two health workers were interviewed as Key Informants. Quantitative data were collected using a questionnaire adapted from the Cervical Cancer Awareness Measure. Quantitative data was analyzed using descriptive statistics and logistic regression using SPSS version 20. Thematic and narrative analyses were used to analyze qualitative data.

Results: This study revealed that only 44.8% (n=168) of mothers were ever screened for cervical cancer and the majority of them (24.3%: n=91) did so only once. The study showed an Odds Ratio (OR) of 44.642 [95% CI: 18.151-109.796, P<0.01], OR of 4.313 for hearing about cervical [95% CI: 1.879-9.902, P=0.001], and OR of 2.457 [95% CI: 1.141-5.290, P=0.022], Barriers found to be affecting screening uptake included: fear of pain, embarrassment, not knowing service availability, lack of perceived benefits, proximity of the facility coupled with lack of transport money, and long waiting time.

Conclusions: The study found that screening uptake was low (44.8%). Barriers to screening include fear of pain, embarrassment, not knowing service availability, lack of perceived benefits, proximity of the facility coupled with lack of transport money, and long waiting time. Participants who were offered Pap smear by health workers were over 44 times more likely to be screened.

Keywords: Antenatal; Cervical Cancer; Postnatal, Pap smear; Screening.

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Introduction

Cervical cancer is one of the most common cancers in women globally. According to the World Health Organization (WHO, 2019), it ranks as the fourth most common cancer among women, with 570,000 new cases and approximately 311,000 deaths reported in 2018. Approximately 55% of all cervical cancer patients

die from the disease. The highest prevalence and mortality rates are in Africa, where the rates are over seven times higher than in other regions (WHO, 2019). Jedy-agba et al., (2020) noted that cervical cancer is a leading cause of morbidity and mortality in countries with the fewest resources, such as Zambia. In Sub-Saharan Africa, cervical cancer is the most common cause of cancer-related deaths in women. Shibemba et al., (2016) indicated that cervical cancer is significantly underestimated in Zambia, suggesting that the problem is more severe than reported. A study by Zyaambo et al., (2013) on cancer distribution in Zambia using data from the Zambia National Cancer Registry between 1990 and 2009 found that cervical cancer was the most common cancer among women in Zambia. In 2018, the WHO reported that Zambia had the third-highest incidence of cervical cancer in the world, with 66.5 new cases per 100,000 women (WHO, 2018).

Early detection is a crucial intervention against cervical cancer, as the disease can be treated effectively when detected at an early stage (WHO, 2019). Developed countries have seen significant declines in cervical cancer incidence and mortality due to frequently repeated cytology screening programs. In contrast, cervical cancer remains largely uncontrolled in high-risk developing countries due to ineffective or inadequate screening (Sankaranarayanan, Budukh, & Rajkumar, 2001). Global cervical cancer prevention efforts have focused on screening sexually active women and treating precancerous lesions.

Kabelenga, Mwanakasale and Siziya (2018) reported that only 22 out of 72 participants (30.6%) were screened for cervical cancer, indicating a very low screening uptake. This study was conducted among medical students, who likely have better awareness and health-seeking behavior compared to the general population, suggesting that screening rates could be even lower among the broader society. Kabalika et al., (2018) found even lower screening rates, with only 2.5% of participants screened for cervical cancer. Nyambe et al., (2019) conducted a study on knowledge, attitudes, and practices of cervical cancer prevention among Zambian women and men, finding that less than half of the respondents (36.8%) had heard of cervical cancer, and only 20.7% of women had attended screening. This highlights the low levels of cervical cancer screening in Zambia, with factors beyond knowledge and attitudes needing exploration, including financial and structural barriers based on the Health Care Access Barriers (HCAB) model.

A retrospective study at the University Teaching Hospital, Zambia's highest referral hospital, conducted between 1997 and 2005, indicated that cervical cancer is the most common cancer among females in Zambia, accounting for 41.5% of cases (Bowa et al., 2009). More than two-thirds of cancer deaths in low- and middle-income countries, including Zambia, are due to various cancers, with cervical cancer being the leading type among females in terms of both morbidity and mortality (Kalubula et al., 2018). Singh, Azuine, and Siahpush (2012) found significant global inequalities in cervical cancer incidence and mortality, with many African countries, including Zambia, having rates at least 10 to 20-fold higher than several West Asian, Middle Eastern, and European countries.

Cervical cancer screening offers protective benefits, and overwhelming evidence supports that screening reduces the incidence of invasive cervical cancer and mortality (Peirson et al., 2013). However, uptake remains low despite high awareness (Ng'ang'a et al., 2018). There is a clear mismatch between the ideal and actual situations in developing countries, where low screening rates lead to increased morbidity and mortality. This contrasts with developed countries, where mortality reductions exceeding 50% have been achieved (Cuzick et al., 2008).

The high mortality and morbidity of cervical cancer in Zambia, despite the potential benefits of screening, necessitate an investigation into the factors affecting screening rates. Previous studies

have primarily focused on cognitive barriers (knowledge, awareness, attitude, beliefs, and education), leaving financial and structural barriers underexplored. There has been little quantification of these barriers to cervical cancer screening in Zambia. Additionally, there is a lack of studies comparing different categories of variables to determine which has the strongest influence on screening uptake. Addressing these gaps can improve screening rates and reduce cervical cancer-related morbidity and mortality in Zambia.

This study therefore aimed at providing statistics on the utilization of cervical cancer screening programs by mothers attending antenatal and postnatal services at Chawama Level One Hospital, a high-risk population. These statistics can inform future screening programs targeted at mothers attending antenatal clinics and similar populations. With Zambia ranked third globally in terms of cervical cancer incidence and mortality as of 2018 (WHO, 2021), understanding barriers to screening is crucial for improving rates. This study focuses on financial, structural, and cognitive barriers, which are inadequately described in most studies, and aims to quantify these factors to help increase screening rates among mothers and reduce cervical cancer-related morbidity and mortality. A better understanding of barriers will inform health promotion activities and sensitization efforts.

Study Objectives

General Objective

The general objective of this study was to investigate uptake rates and barriers to cervical cancer screening among mothers attending antenatal and postnatal services at Chawama Level I Hospital.

Specific Objectives

The specific objectives of this study were to:

1. Determine cervical cancer screening uptake among mothers attending antenatal and postnatal services at Chawama Level I Hospital.
2. Investigate the barriers to cervical cancer screening among mothers attending antenatal and postnatal services at Chawama level I Hospital.

Conceptual Framework

The Conceptual Framework was associative in nature and attempted to link three major categories of factors that tend to affect cervical cancer screening rates. It was driven from three aspects; firstly, the theoretical framework (Health Care Access Barrier Model), secondly the researcher's synthesis of relevant literature, and thirdly the researcher's point of view as well as observations on the subject.

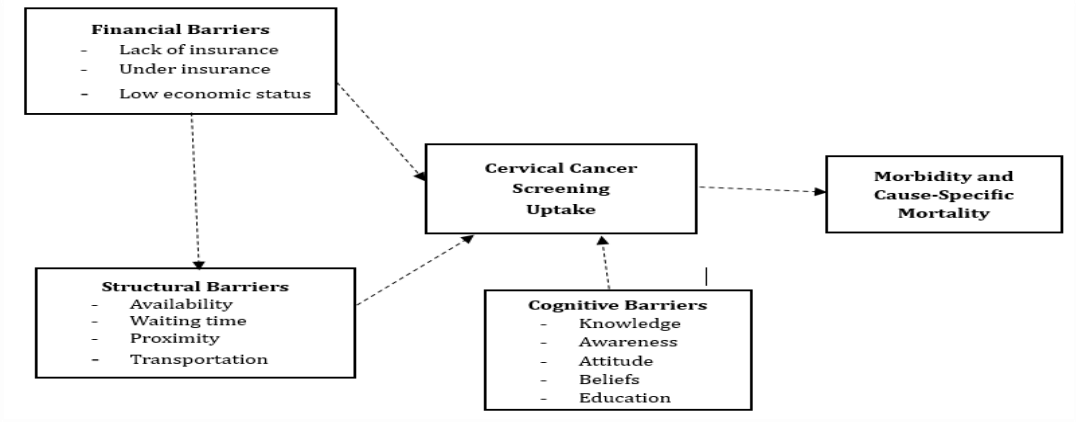

Figure 1: Conceptual Framework

Source: Conceptualized by the authors (2024)

Methodology

Study Design

Following the nature of objectives in this study, a cross-sectional, equal priority mixed method approach was used. Researchers combined both qualitative and quantitative data in terms of viewpoints, data collection, data analysis, and inference techniques in an attempt to achieve research objectives. The type of mixed method used in this study was the Triangulation Design as the researchers implemented quantitative and qualitative methods during the same timeframe.

Study Setting

The study was conducted at Chawama Level I Hospital, a public health facility in Lusaka, serving approximately 70,181 residents and surrounding areas. As at April, 2022, the hospital attended to 6,624 mothers for prenatal, antenatal, and postnatal services.

Study Population

All mothers attending antenatal and postnatal services at the facility, health workers involved in screening, and those coordinating the program participated in the study.

Inclusion and Exclusion Criteria

Inclusion Criteria: Women attending antenatal and postnatal services who consented to participate, and screening staff with at least one year of experience.

Exclusion Criteria: Staff without training in cervical cancer screening, pregnant mothers in active labour, and those just discharged post-delivery.

Sample Size

Using the sample size calculator and a population of 6,624, a 5% margin of error, and a 95% confidence level, the calculated sample size was 364. Including a 10% nonresponse rate, the target sample was 401 participants. The sample size (n) is calculated according to the formula: $n = [z^2 * p * (1 - p) / e^2] / [1 + (z^2 * p * (1 - p) / (e^2 * N))]$

Where: z = 1.96 for a confidence level (α) of 95%, p = proportion (expressed as a decimal), N = population size, e = margin of error.

z = 1.96, p = 0.5, N = 6624, e = 0.05

n = [1.962 * 0.5 * (1 - 0.5) / 0.052] / [1 + (1.962 * 0.5 * (1 - 0.5) / (0.052 * 6624))]

n = 384.16 / 1.058 = 363.102, n ≈ 364

The sample size (with known population as indicated above) is equal to 364. Adding a 10% nonresponse rate gives a sample of 401. Therefore, the study targeted a sample size of 401 participants.

Research Instruments and Data Collection

Three tools were used: questionnaires, Focus Group Discussions (FGDs), and Key Informant Interviews (KIIs). Two research assistants fluent in the local language assisted with data collection and FGDs. KIIs were conducted with key informants using a pre-tested schedule based on the WHO Health System Building Blocks.

Quantitative Data Collection: A questionnaire adapted from the Cervical Cancer Awareness Measure (Cervical CAM) and supplemented with relevant questions. The CAM is validated for measuring awareness of cancer symptoms and barriers to help-seeking.

Qualitative Data Collection: Key Informant Interviews (KIIs) with facility staff using a guide based on WHO Health System Building Blocks. FGDs included six mothers each, selected purposefully to discuss financial, cognitive, and structural barriers. Guides were adapted from existing research tools.

Data Analysis

Quantitative Analysis: SPSS version 20 was used for descriptive statistics, generating frequency tables, pie charts, and bar charts. Bivariate analysis and binary logistic regression identified significant associations between independent variables and cervical cancer screening uptake.

Qualitative Analysis: Thematic and narrative analysis were used. Thematic analysis identified patterns in KIIs and FGDs, categorized into financial, structural, and cognitive barriers based

on the Health Care Access Barrier (HCAB) Model. The narrative analysis provided in-depth insights into experiences and challenges, ensuring a hybrid deductive-inductive approach.

Ethical Considerations

The current study's ethical clearance was obtained from the University of Lusaka Research Ethics Committee under approval reference number "FWA0003322-1406/23", and permission to conduct research was obtained from the Zambia Health Research Authority (ZHRA). The Lusaka Provincial and Lusaka District Health Offices granted permission for conducting interviews in the province and district respectively. Further, authorization was granted by the Hospital Administration in order to collect data at the facility. Female research assistants facilitated discussions to ensure comfort and confidentiality. Pregnant mothers in active labor were excluded, and necessary medical support was available. Participants received information sheets, and consent forms were adapted from WHO guidelines. The study maintained participant anonymity throughout.

Results

Socio-demographic Characteristics of the Study Participants

Out of 401 distributed questionnaires, 384 were completed and returned, yielding a response rate of 95.7%. Table 1 below presents demographic characteristics of participants and the corresponding P-values and Cramer's V in relation to their association with cervical cancer screening uptake.

Characteristic	Percentage Distribution; n(%)	P - Value	Cramer's V
Age	21 to 29 years - 53% (n=202)	0.0001	0.333
	30 to 35 years - 30.7% (n=117)		
	36 to 40 years - 12.6& (n=12)		
	Unknown - 0.5% (n=2)		
Marital Status	**Married - 72.7% (n=279)**	0.404	0.07
	Single - 26.8% (n=103)		
	Unknown - 0.2& (n=2)		
Number of Children	**0 to 2 - 63.3% (n=226)**	0.001	0.201
	3 to 5 - 34.7% (n=124)		
	Above 6 - 2% (n=7)		
Number of Pregnancies	**0 to 2 - 44% (n=169)**	0.0006	0.255
	3 to 5 - 45.19% (n=173)		
	Above 6 - 3.9% (n=15)		
Level of Education	**College/University - 39.4% (n=151)**	0.442	0.085
	Primary/Secondary - 29.4% (n=114)		
	No formal Education - 7.6% (n=29)		
	Unknown - 23.2% (n=87)		
Employment Status	Full time/part time - 20.1% (n=77)	0.002	0.196
	Self-employed - 23% (n=88)		
	Unemployed - 55% (n=211)		
	Unknown - 2.1% (n=8)		
Economic Status	**Low class - 85.9% (n=330)**	0.009	0.178

	Middle class - 11.4% (n=44)		
	High class - 2.7% (n=10)		

Awareness of Cervical Cancer Screening

The present study showed that 82.7% (n=311) of the study participants were aware of cervical cancer screening services being offered at the study site. However, some study participants confirmed resistance towards the uptake of the cancer screening services as highlighted by Participant #6 during the Focus Group Discussion (FGD). Additionally, Participants #2, #6, #8, and #9 indicated that health workers always encourage them to access cancer screening services during the community outreach programmes if they encounter challenges in visiting the health facilities.

Cervical Cancer Screening Uptake

The results of the present study showed a low (44.8% (n=168) cervical cancer screening uptake, with the majority (55.2%: n=207) being participants who had never screened for cervical cancer in their lifetime. Even among those who had ever screened, the majority of them (24.3%; n=91) had done so only once (Fig 3). The responses from the FCD pointed to fear of pain during the procedure, embarrassment, lack of knowledge, shyness, and lack of transportation to the cancer screening sites as reasons for the low screening uptake. Interestingly, the study revealed that 82.7% of participants (n=311) had heard about cervical cancer screening before.

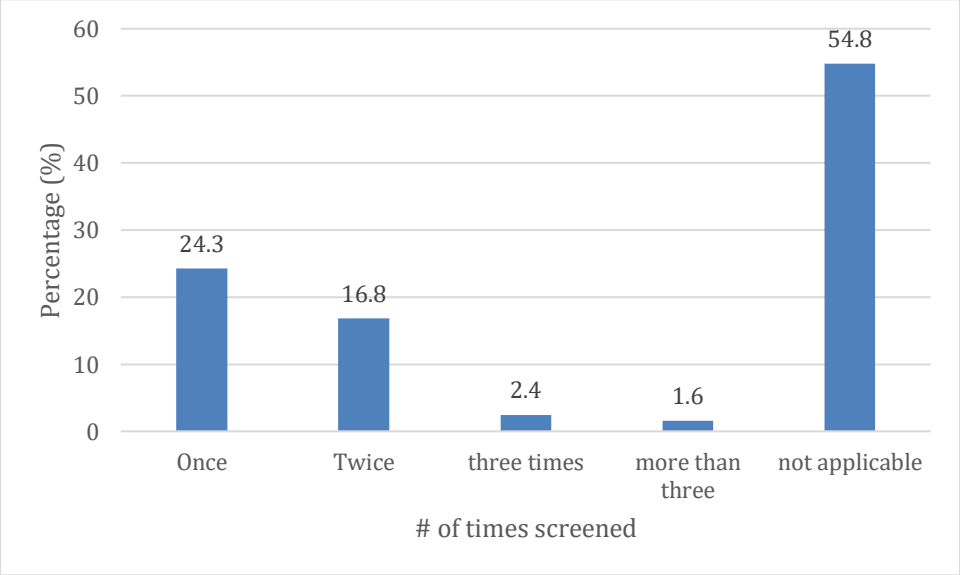

Figure 3: Number of Times Participants Screened.

The following narratives highlight some of the comments given by participants during Focus Group Discussions and provide reasons for not screening;

Participant #15: Yes, I actually came and joined the queue…while in the queue I thought about the metal they insert and how painful it is so I changed my mind and went back home without screening.

Participant #10: We are scared and also feel shy in the end…that is why we do not go for screening. I go there, they screen me…I don't even know what is there.

Participant #8: We are shy of someone seeing our nakedness.

Participant #16: Yes, I came right at this facility, then I noticed there was a very young person who was conducting the screening so I failed to screen, I felt shy that's why I went back.

Correlation between Independent Demographic Variables and Screening Uptake

Independent demographic variables were analyzed to determine their correlation with screening uptake. Among the demographic factors under investigation, age, number of children, number of pregnancies, employment status and economic status of the study participants showed a significant association with the uptake of cancer screening services as shown in Table 2.

Demographic Characteristic	P - Value	Cramer's V
Age	0.007	0.333
Marital Status	0.404	0.07
Number of Children	0.001	0.201
Number of Pregnancies	0.003	0.255
Level of Education	0.442	0.085
Employment Status	0.002	0.196
Economic Status	0.009	0.178

Table 2: Correlation between Independent Demographic Variables and Cervical Cancer Screening Uptake.

Binary Logistic Regression Analysis for Demographic Variables

In order to predict and determine the amount of variance explained by each of the five significant demographic variables, binary logistic regression was performed. Table 3 shows that only age and number of pregnancies were significantly associated with the outcome variable. Goodness-of-fit of this binary logistic model was evaluated using a likelihood ratio test, with a chi-square statistic of $\chi2(8, N=384) = 64.361$, $P < .001$. The model further gave Cox & Snell R Square of 0.176 (R^2=0.176) and Nagelkerke RSquare of 0.236 (R^2=0.236). As a way of further evaluating the model's goodness-of-fit, the Hosmer and Lemeshow Test was considered and showed that the P-value was insignificant; $\chi2(8, N=384) = 9.902$, $P= 0.272$ which was greater than 0.05. The model further showed the specificity and sensitivity of 79.3% and 51.4% respectively. The model had an overall percentage accuracy of 66.9%.

Demographic Variable	OR	P-value	CI
Age (Years)	2.065	0.000	[1.422,2.998]
No of Pregnancies	2.060	0.000	[1.098,3.863]
Employment Status - Full/Part-time	1.489	0.281	[0.722,3.068]
Employment Status - Self-Employed	0.715	0.289	[0.385,1.329]
Employment Status - Not Employed	0.867	0.878	[0.141,5.333]
Economic Status - Low	1.565	0.217	[0.768,3.189]

Economic Status - Middle		0.999	
Economic Status - High		0.469	

Table 3: Binary Regression Analysis for Demographic Variables.

Cervical Cancer Awareness Variables and Screening Uptake

Using cross-tabulations, the current study further analyzed the correlation between cervical cancer screening uptake and six cervical cancer awareness variables. Using Cramer's V and P-value set at 0.05, all six awareness variables were statistically significant with varying strengths of association. (Table 4)

Awareness Variable	P-value	Cramer's V
Heard about CC	0.001	0.170
Know someone who died of CC	0.002	0.167
Heard about CC from Health Worker	0.000	0.351
Heard about HPV	0.000	0.407
Know HPV	0.000	0.387
Heard about CC Vaccine	0.000	0.383

Table 4: Correlation between Awareness variables and CC Screening Uptake.

Binary Logistic Regression Analysis for Cervical Cancer Awareness Variables

The seven cervical cancer awareness variables were further subjected to binary logistic regression in order to determine the amount of variance explained by each of them on whether a mother will be screened for cervical cancer or not. Binary logistic regression revealed that being offered a pap smear, having been talked to by a health worker, hearing about HPV, and knowing about the vaccine were significantly associated with the uptake of cancer screening services among the study participants (Table 5).

The Omnibus Tests of model's goodness-of-fit revealed $\chi2(7, N=384) = 223.341$, $P< .001$. This was further supported by Hosmer and Lemeshow Test which gave a P-value greater than 0.05; $\chi2(8, N=384) = 5.297$, $P = 0.725$ ($P>0.05$). The Cox & Snell R Square was 0.519 ($R^2=0.519$) and Nagelkerke R Square of 0.694 ($R^2=0.694$). The model further showed the specificity and sensitivity of 83.2% and 87.0% respectively. Overall, the model has a percentage accuracy of 84.9%.

Awareness Variable	OR	P-value	CI
Pap smear offer by a health worker	42.77	0.000	[17.915,102.104]
Having been talked to by a health worker over CC	2.777	0.015	[1.224, 6.301]
Hearing about HPV	7.496	0.001	[2.191, 26.641]
Hearing about vaccine against CC	3.202	0.003	[1.491, 6.873]
Hearing about CC	0.869	0.84	[0.221, 3.419]

Knowing about HPV	0.721	0.603	[0.210, 2.474]
Knowing someone who died of CC	0.392	0.033	[0.166, 0.925]

Table 5: Binary Regression Analysis for Awareness Variables.

Binary Logistic Regression Analysis for Demographic and Cervical Cancer Awareness Variables

After performing separate analyses on demographic and cervical cancer awareness variables, binary logistic regression was performed on these two sets of variables by considering only those specific variables that were statistically significant. The analysis produced an Odds Ratio (OR) of 44.642 for a pap smear offered by a health worker, OR of 4.313 for hearing about HPV, and OR of 2.457 for hearing about cervical cancer vaccine. The rest of the variables in the model were not statistically significant (Table 6).

Demographic and Awareness Variable	OR	P-value	CI
Pap smear offer by a health worker	44.642	0.000	[18.151, 109.796]
Having been talked to by a health worker over CC	2.150	0.069	[0.942, 4.908]
Hearing about HPV	4.313	0.001	[1.897, 9.902]
Hearing about vaccine against CC	2.457	0.022	[1.141, 5.290]
Knowing someone who died of CC	0.471	0.790	[0.203, 1.090]
Age (Years)	1.386	0.226	[0.817, 2.352]
No of Pregnancies	0.925	0.848	[0.419, 2.044]

Table 6: Binary Regression Analysis for Awareness and Demographic Variables.

The Omnibus Tests of the model's goodness-of-fit revealed $\chi 2(7, N=384) = 218.090$, $P< .001$, implying that the model adequately explains the data. This was further supported by Hosmer and Lemeshow Test which gave a P-value greater than 0.05; $\chi 2(8, N=384) = 9.006$, $P = 0.342$ ($P>0.05$). The Cox & Snell RSquare was 0.521 ($R^2=0.521$) and Nagelkerke R Square of 0.698 ($R^2=0.698$). The model further showed the specificity and sensitivity of 83.5% and 88.6% respectively. Overall, the model has a percentage accuracy of 85.8%.

Reasons for Not Screening Based on Key Informant Interviews

Structural factors given by Key Informants included; screening service being targeted primarily at patients on ART, shortage of materials used for screening, lack of extra incentive for screening staff, and inadequate screening staff. Some of the comments from key informants were as follows;

Key Informant #1: The response is ok at the moment depending on the ART because we target the ART, and then the people from the community come, but not very much, but those on ART we have a lot

Key Informant #2: "At times we would go with a shortage but not for a very long time…we are being supplied by the Province". This Key Informant gave this response when asked if the facility tends to have a shortage of screening materials.

Key Informant #2: "No no…apart from maybe what we get when we go for outreach…" This response was given when Key Informants were

asked if they get any extra incentives for conducting cervical cancer screening services.

Key Informant #1: At the moment we are trying…I wouldn't say excellent, but we are somewhere because it was worse years before.

Discussion

The current study revealed that 44.8% of mothers attending antenatal and postnatal services at the facility had undergone cervical cancer screening, indicating that the majority, 55.2%, had not. This finding aligns with various studies showing differing rates of cervical cancer screening uptake. In comparison to this study, Wakwoya et al., (2023) reported a 49.7% agreement to screening, though their participants had not necessarily been screened prior to the study. This distinction emphasizes the current study's focus on actual screening rates among mothers. Similarly, Maitanmi et al., (2023) found that 47.5% of university undergraduates were willing to screen, but this did not reflect actual screening practices. Willingness to screen, as shown in studies like Zhang et al., (2023), where 84% were willing but only 40% had screened, often does not equate to actual screening uptake.

Lower screening rates were reported by Kabalika et al., (2018), Ezechi et al., (2013), and Gitonga et al., (2022), who reported lower screening rates of 2.5%, 9.4%, and 20%, respectively. These studies typically measured screening prior to study recruitment, aligning with the current study's approach, and highlighted low screening uptake among women.

This study revealed that screening practice was irregular as most mothers (24.3%) screened only once. This irregularity is corroborated by Gitonga et al., (2022), who found that less than half of those who screened (20%) did so regularly. Despite 82.7% of participants being aware of cervical cancer screening, the uptake remained low. Focus group discussions confirmed this awareness but also revealed that participants did not know why they never screened, despite community sensitization efforts.

The study identified several barriers to screening through both qualitative and quantitative analyses. The logistic model explained 52.1% to 69.8% of the variance in screening uptake, highlighting key predictors. Notably, mothers offered a pap smear by health workers were 45 times more likely to screen, emphasizing the impact of health worker recommendations. This finding is consistent with literature indicating that recommendations from health workers significantly influence screening decisions (Vega Crespo et al., 2022; Black, Hyslop & Richmond, 2019; Ebu & Mupepi, 2015).

Additionally, mothers who had heard about HPV were over 4 times more likely to be screened, underscoring the importance of awareness in promoting screening. Although specific evidence linking HPV awareness to screening uptake is limited, generally low levels of knowledge and awareness are known barriers (Binka et al., 2019). Hearing about the cervical cancer vaccine also increased screening likelihood, though to a lesser extent.

Contrary to many studies, demographic variables such as age, education level, and economic status did not significantly influence screening decisions in this study. This contradicts findings from studies like Maitanmi et al., (2023) and Ezechi et al., (2013), which identified these variables as predictors of screening uptake. The current study's focus on actual screening rates among high-risk mothers, rather than acceptance to screen, may account for these differences.

Focus group discussions and key informant interviews revealed additional barriers, including fear of the procedure and embarrassment. Many participants reported hearing that the screening process was painful, leading them to avoid it. This fear is supported by literature identifying pain and embarrassment as significant barriers (Ampofo et al., 2020; Moucheraud et al., 2022; Petersen et al., 2022). Embarrassment was further compounded when the screening was conducted by younger or opposite-gender health workers, causing some

participants to abandon screening despite initially intending to undergo the procedure.

Conclusion

The study revealed that cervical cancer screening uptake among antenatal and postnatal mothers at Chawama Level One Hospital was low, with only 44.8% having been screened. Significant factors influencing screening uptake included pap smears offered by health workers, hearing about HPV, and awareness of vaccines against cervical cancer. Despite high levels of awareness, several barriers hindered screening uptake. Fear of pain and embarrassment, lack of knowledge about the procedure, and logistical challenges such as transportation were reported obstacles. Other barriers identified were lacking knowledge of the importance of screening for cervical cancer, and not being aware of the availability of screening services at the hospital. Negative influence from others and misinformation. Facility-related barriers included a lack of screening service in some rural health centers and long queues at the screening center. The findings emphasize the critical role of health worker recommendations in encouraging screening and the need for targeted education to address misconceptions and fears about the screening process.

Limitations

The following were the limitations as the study did not;

1. Involve screening mothers for cervical cancer
2. Determine mothers' willingness to screen for cervical cancer.
3. Involve inviting mothers to take a pap smear.

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